

Bureau of Health Care Quality and Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>NVS176AGC</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>10/07/2009</b>
NAME OF PROVIDER OR SUPPLIER  <b>THE ROSE OF SHARON</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>355 EVAN PICONE HENDERSON, NV 89014</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y 000	<p>Initial Comments</p> <p>Surveyor: 28384</p> <p>The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws.</p> <p>This Statement of Deficiencies was generated as a result of a required grading re-survey conducted in your facility on October 7, 2009. This State Licensure survey was conducted by the authority of NRS 449.150, Powers of the Health Division.</p> <p>The facility is licensed for eight Residential Facility for Group beds for elderly and disabled person and/or persons with mental illness. The census at the time of the survey was eight. Eight resident files were reviewed and four employee files were reviewed.</p> <p>The facility received a survey grade of A.</p> <p>The following deficiencies were identified:</p>	Y 000		
Y 105 SS=D	<p>449.200(1)(f) Personnel File - Background Check</p> <p>NAC 449.200</p> <p>1. Except as otherwise provided in subsection 2, a separate personnel file must be kept for each member of the staff of a facility and must include:</p> <p>(f) Evidence of compliance with NRS 449.176 to 449.185, inclusive.</p>	Y 105		

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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Y 105	Continued From page 1  This Regulation is not met as evidenced by: Surveyor: 28384 Based on record review on October 7, 2009, the facility failed to ensure 1 of 4 caregivers met background check requirements (Employee #4).  This was a repeat deficiency from the July 7, 2009 State Licensure survey.  Severity: 2 Scope: 1	Y 105		
Y 878 SS=D	449.2742(6)(a)(1) Medication / Change order  NAC 449.2742 6. Except as otherwise provided in this subsection, a medication prescribed by a physician must be administered as prescribed by the physician. If a physician orders a change in the amount or times medication is to be administered to a resident: (a) The caregiver responsible for assisting in the administration of the medication shall: (1) Comply with the order.  This Regulation is not met as evidenced by: Surveyor: 28384 Based on record review and interview on October 7, 2009, the facility failed to ensure that 1 of 8 residents received medications as prescribed (Resident #4).  This was a repeat deficiency from the July 7, 2009 State Licensure survey.	Y 878		

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Y 878	Continued From page 2  Severity: 2 Scope: 1	Y 878			

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